Maryland CANCER FUND

Organization Application

(Please Type or Print Clearly)

Name of Contact: _____
Name of Organization/Entity: _____
Address: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Name of Individual Patient Requiring Cancer Treatment: _____
Date of Birth: _____
Gender: _____
County of Residence: _____
Type & Stage of Cancer: _____

Please complete the following checklist for enclosures:

- ☐ Completed MCF Cancer Treatment Application, along with:
  - ☐ Proof of health insurance policy, if applicable
  - ☐ Proof of residency eligibility
  - ☐ Proof of annual family income or notarized statement of no income
- ☐ Physician letter (on physician's letterhead confirming individual diagnosed with cancer, treatment for cancer, or finding suggestive of cancer, date of diagnosis or treatment, specialty, medical license number)
- ☐ Treatment Plan and Budget
- ☐ Certification
- ☐ Consent
- ☐ Fiscal Budget Forms DHMH 432 A – H